

MDR Tracking Number: M5-04-3942-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 7-19-04.

The IRO reviewed unlisted physical medicine/rehabilitation service (97799) and office visits from 7-28-03 to 8-27-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 8-11-04 and 9-13-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the medical fee charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Codes 97139 billed on dates of service 7-28-03 to 8-27-03 was denied as "N, 138 – CPT code does not match service rendered"

Daily notes dated 7-28-03 to 8-27-03 state "treatment with the Matrix System providing a Non-Invasive Nerve Block and a Vasopneumatic application to decrease localized and radicular pain as well as edema around the injured tissue..." Per Trailblazer Local Coverage Determination (LCD), "For all claims submitted with an unlisted procedure code, a complete narrative description (detailing the service or procedure being performed) and the treatment plan must be submitted with the claims." A complete narrative description was not provided with a treatment plan for the disputed dates of service. Therefore, no reimbursement recommended.

Code 97016 billed on dates of service 7-28-03 to 8-27-03 was denied as "N, 161 – submitted report does not meet FS guidelines". The attached sheet to the SOAP notes supports service rendered. Recommend reimbursement of  $\$14.47 \times 125\% = \$18.09 \times 14 \text{ days} = \$253.26$ .

Code 97265 billed on date of service 7-28-03 to 7-31-03 was denied as "N, 161 – submitted report does not meet FS guidelines". SOAP notes did not support service rendered. Therefore, no reimbursement recommended.

Code 99211 billed on date of service 7-30-03 was denied as "N – CPT code does not match service rendered." SOAP note supports level of service billed. Recommend reimbursement of \$18.00

Code 99211 billed on date of service 7-31-03 had no EOB submitted by either party. Note: The EOB submitted for this date of service was for code 99213. Code 99211 was billed per the HCFA. Therefore, this service will be reviewed per the 1996 MFG. Per Rule 133.307(e)(2)(B), the requestor did not submit convincing evidence of carrier receipt of the provider request for an EOB. Per Rule 133.307(e)(3)(B), the

respondent did not providing the missing EOBs not submitted by the requestor with the request. Therefore, no review could be conducted and no reimbursement recommended.

Code 97010 billed on dates of service 8-4-03, 8-7-03-, 8-8-03, 8-15-03, 8-18-03, 8-22-03, and 8-27-03 was denied as “G, 100 – included in another billed procedure. Procedure code 97010 will be bundled into the payment for all other services including, but not limited to, office visits and physical therapy.” The Trailblazer Local Coverage Determination (LCD) states that code 97010 is a bundled code and considered an Integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed. Therefore, no reimbursement recommended.

Code 97140-59 billed for date of service 8-22-03 was denied as “N, 116 – myofascial release/per Medicare/LMRP guidelines, timed units of physical medicine must include documentation that reports actual amount of time spent on a cumulative basis.” Per the HCFA, only one unit was billed. SOAP note supports myofascial release to the hamstring area.

- Code 97140-59 –Recommend reimbursement of  $\$27.24 \times 125\% = \$34.05$ .

Code 99214 billed for date of service 8-27-03 was denied as “N - submitted report does not meet FS guidelines.” This level of service requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. SOAP note supports detailed examination and medical decision making of moderate complexity.

- Code 99214 - Recommend reimbursement of  $\$103.24$  ( $\$82.59 \times 125\% = \$103.24$ ).

Code 99456-WP billed for date of service 9-23-03 was denied as “F, 510 – payment determined and Fee Guideline MAR reduction.” Per Rule 134.202 (6) (C) (iii), an examining doctor shall bill using the ‘work related or medical disability examination by other than the treating doctor...’. Reimbursement shall be \$350.00. Per Rule 134.202 (6) (D)(iii)for musculoskeletal body areas, the examination doctor may bill for a maximum of three body areas. Per Rule 134.202 (6)(D)(iii) (I), Musculoskeletal body areas are defined as spine and pelvis; upper extremities and hands; and lower extremities (including feet). Per Rule 134.202 (6)(D)(iii) (II), the MAR for musculoskeletal body areas shall be as follows: (-a-) \$150.00 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4<sup>th</sup> edition is used.

The IR report submitted by the Requestor supports impairment rating of one body area. Therefore, reimbursement is \$350.00 for the exam and \$150.00 for the musculoskeletal DRE =

\$500.00. The Requestor billed \$650.00 and the Respondent paid \$500.00. No additional reimbursement recommended.

## **ORDER**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- In accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
- Plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 7-28-03 through 8-27-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 5th day of November 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

## **NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** September 7, 2004

**RE:**

**MDR Tracking #:** M5-04-3942-01  
**IRO Certificate #:** 5242

\_\_\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for

independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

**Submitted by Requester:**

- Various examinations dated 7/25/03, 8/13/03 and 8/27/03
- Multiple daily notes from 7/25/03 through 9/23/03
- Several explanation of benefits pages and billing documents from the range of disputed dates of services

**Submitted by Respondent:**

- Peer review report from \_\_\_\_\_ dated 9/5/03

**Clinical History**

According to the documentation submitted for review, the claimant slipped off a curb while carrying an extension ladder and this caused him to hurt his low back on \_\_\_\_\_. The claimant underwent some chiropractic care and was eventually referred over for lumbar traction services. The lumbar traction services, as well as the office visits are the items in dispute in this file. An MRI of the claimant's lumbar spine revealed facet degenerative changes from L3/4 through L5/S1. There was a 3mm focal left foraminal disc substance herniation at the L4/5 level as well as a disc annular tear with a 2mm symmetric annular bulge at the L5/S1 level. The L3/4 level demonstrated a 2mm symmetric annular disc bulge. The claimant underwent chiropractic therapy with \_\_\_\_\_ and was placed back on restricted duty as of 6/24/03. The claimant was referred to another chiropractor where he received vertebral axial decompression. The machine or mechanism which produced the axial decompression was the DRX-9000 low back system. This is a newer type of system and it is not necessarily classified as VAX-D. I will discuss this to some degree in the rationale portion of this report.

**Requested Service(s)**

Unlisted physical medicine/rehabilitation service or procedure (97799), office visits (99211, 99212) from dates of service 7/28/03 through 8/27/03. It should be noted that the claimant did undergo a 99214 level office visit on 8/27/03.

**Decision**

I agree with the insurance carrier and find that the services in dispute were not medically necessary as documented.

**Rationale/Basis for Decision**

While VAX-D and more sophisticated devices based on this technology have anecdotal evidence of efficacy, there are no scientific studies (randomized, controlled, and double-blinded) which

prove long-term benefit such devices. Official Disability Guidelines (ODG), which is evidence-based, makes the following statement:

Not recommended. While there are some promising studies, the evidence in support of vertebral axial decompression is insufficient to support its use in low back injuries. Vertebral axial decompression for treatment of low back injuries is not recommended. VAX-D therapy may also have risks, including the potential to cause sudden deterioration requiring urgent surgical intervention.

Those studies, quoted in ODG, that appear to support VAX-D have no documentation of follow-up after the completion of treatment, with regard to either prolonged pain relief or return to work. There are no studies which compare VAX-D to a McKenzie protocol. Considering that low back pain is a common ailment, it is puzzling why the manufacturers' of these devices, if not prior to releasing the devices on the market, have not, since then, commissioned a large scientific study proving the efficacy of their device. It appears to have been released to the public by the FDA under the 510(k) exemption, which means that it is at least as safe and probably as effective as similar devices, in this case, simple traction. It remains a passive modality of questionable long-term benefit. Until there are more evidence-based studies proving effectiveness, it is my opinion that its use cannot be considered medically necessary.